MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

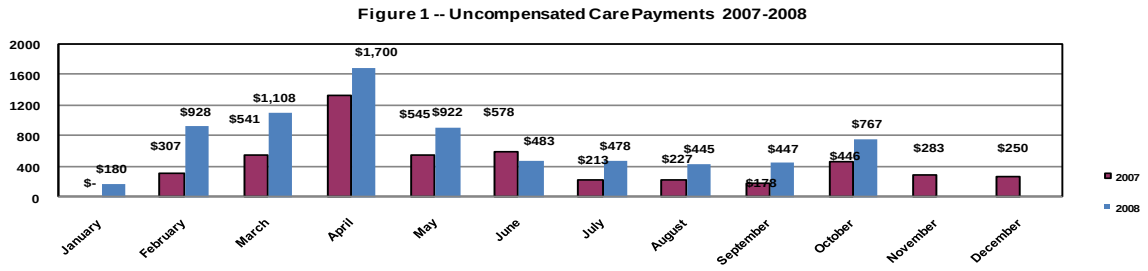
November 2008

CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Maryland Trauma Physician Services Fund

Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $776,775 in October. The monthly payments for uncompensated care over the past 21 months are shown in Figure 1.



Trauma Equipment Grants

Trauma Centers were required to disburse all funds from the 2007 equipment grants no later than June 30, 2008 and send an itemized disbursement report to the Commission directly thereafter. All Level I and Level III trauma centers have submitted a grant closeout report describing the final disposition of the grant. Funds not expended were returned to the MHCC. The Trauma Equipment Grant application for FY 2009 will be posted to the Commission's website this month.

SB 916 – Maryland Trauma Physician Services Fund – Reimbursement and Grants

The Commission is required to implement the new law (signed by Governor Martin O'Malley on April 24th) effective July 2008. Staff is drafting proposed changes to COMAR 10.25.10 to conform with the statutory changes in consultation with staff members from the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the Health Services Cost Review Commission (HSCRC), and the members of TraumaNet.

Operations from July 1, 2007 through June 30, 2008, Report to the General Assembly

The Commission's staff, in conjunction with the staff of the Health Services Cost Review Commission, is required to report to the General Assembly on the status of the Fund each November. This year's report has been sent to the General Assembly and posted to the Commission's website.

Cost and Quality Analyses

Report on Differences In Hospitalizations For Ambulatory Care Sensitive Conditions Among Maryland Medicare Beneficiaries – 2006

The MHCC and the DHMH office of Minority Health undertook this study to expand policymakers understanding of health care disparities in the state. Hospitalization for ambulatory care sensitive conditions (ACSCs)—conditions for which timely and appropriate outpatient care could prevent many hospitalizations—is a frequently used marker for the quality of the outpatient care system. Researchers have found that the performance of outpatient care systems can include both quality of care delivered by individual providers and system-level factors that affect patient access to care. High rates of ACSC-related hospitalizations may indicate problems with the quality of care in outpatient health care systems. Differences in rates between different groups could arise from inequities in the quality of care, although differences in disease burden and other factors are also likely to play a role.

The analysis of Maryland Medicare claims data showed significant differences in rates of ACSC-related hospitalizations by race and gender that were only partially explained by factors such as disease burden, socioeconomic, and geographic factors. Rates also varied significantly by county, when controlling for differences in population characteristics. Mathematica Policy Research will present the findings from this analysis and discuss possible opportunities for improvement in the outpatient health care system at the November meeting. The issue brief and a detailed report describing the methods used will be released in December.

Health Insurance Coverage
In December, MHCC staff will present findings from this year's *Health Insurance Coverage in Maryland* report, which will explore insurance coverage among the state's nonelderly residents in 2006-2007. The report is heavily used by legislators and other state policy-makers during the legislative session which begins in early January.

Task Force on Health Care Access & Reimbursement
The Center for Information Services and Analysis staff continues to serve as staff to the Governor's Task Force on Health Care Access & Reimbursement. The Task Force met on November 3rd to vote on recommendations from the Task Force in nine areas as specified in by Senate Bill 107 (Chapter 505 of 2007 Laws of Maryland), as amended by Senate Bill 744 in 2008. The following recommendations were adopted at the November 3rd meeting.

1. **Recommendations For Simplifying The Credentialing Of Physicians By Hospitals and Health Plans**

    - MIA and OHCQ should align physician credentialing requirements with those adopted nationally by CAQH, a national not-for-profit organization of health plans and trade associations established to increase the efficiency of credentialing.
    - The MIA and OHCQ should support CAQH proposals to conduct primary source verification on behalf of health plans and hospitals.
    - The MIA and OHCQ should encourage NCQA and JCAHO to endorse primary source verification by CAQH.
    - The MIA and OHCQ should undertake a study of factors that contribute to credentialing delays by health plans and hospitals.

2. **Recommendations on Changing the Payment to Non-participating Physicians that provide Covered Services to HMO Patients**

    - The General Assembly should amend Health General Article §19.710.1 by increasing payments for evaluation and management services to the greater of 140 percent of Medicare or 125 percent of the average of what a similarly licensed in-network provider is reimbursed in the same Medicare area. Other non-participating services should be reimbursed at 125 percent of the average of what a similarly licensed in-network provider is reimbursed in the same Medicare area.
    - Current law for reimbursement of providers treating PPO patients should not be changed.

3. **Recommendations On Approaches To Promote Practice Formation In Maryland**

    - The Health Services Cost Review Commission should allow hospitals in physician shortage areas to establish loan forgiveness approaches in exchange for a physician's commitment to practice in the shortage area—similar to the Nurse Support Programs I and II provided that such a program: (1) is in the public interest; and (2) is not in violation of the State's Medicare waiver under Section 1814(b) of the Social Security Act.
    - Maryland government should encourage universities to offer tuition assistance and admission preference to qualified in-state applicants who agree to stay and practice in underserved areas for five years.
    - Medical practices should be designated by the Maryland General Assembly as eligible to participate in state incubators and technical assistance programs established by the Maryland Department of Business Development.
    - Insurance carriers and health plans should provide incentive payments to practices in shortage areas for technology upgrades/medical home development/expanded hours, etc.

4. **Recommendation For Reimbursing Primary Care Providers That Provide Mental Health Services**

    - Convene a Task Force of payers and providers to: (1) study and correct claims coding issues associated with services provided by primary care providers and (2) correct misconceptions through primary care provider education.

Data and Software Development

Internet Activities

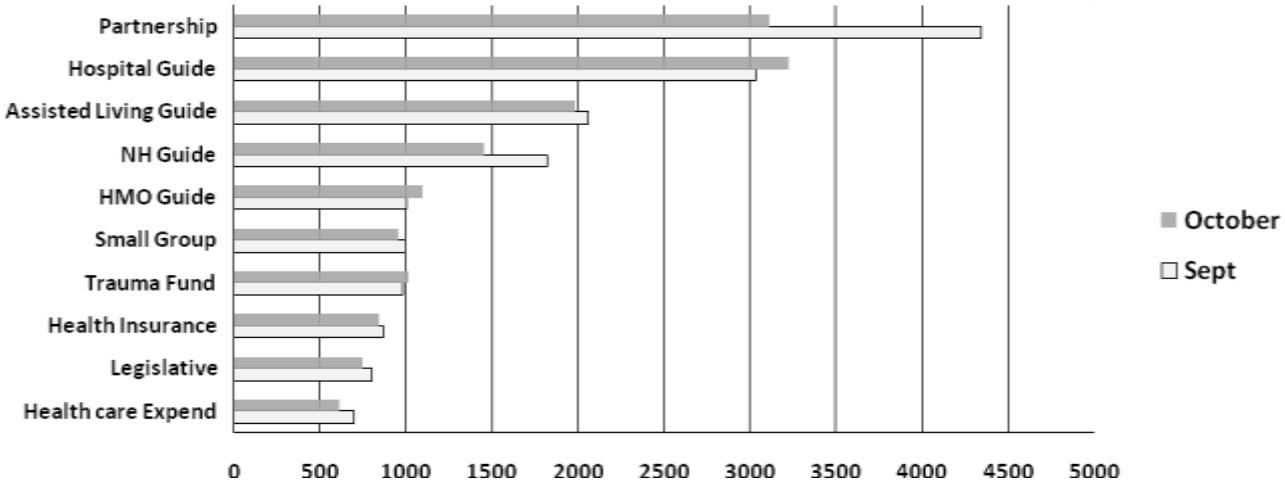
Figure 2 presents results on web utilization for the Commission's ten most frequently visited sites for February, September, and October of this year. Visits in the last two months have been steady with August totals at about 26,000.

The Health Insurance Partnership, the LTC Survey (an on-line survey administered by MHCC), and Electronic Health Initiatives had about 3,100 visits in October, down from the 4,300 in September. Electronic Health Initiatives also saw significant growth in visitors. The Hospital Performance Guide, shown as "Hospital Guide" below, was the site with the highest utilization in October. It continues to be one of the most heavily visited sites. The Guides (Hospital, Assisted Living, and Nursing Home) all had

significant traffic during the month. The release of the 2008 HMO Guide pushed the HMO initiative into the top ten.

Several web analytics continued to trend favorably last month. The average number of pages viewed increased as did the average time on the site. About one-third of all visitors originate from a Maryland-based ISP. Those visitors tend to view more pages and spend a longer time on the site.

Figure 2: Visits to the MHCC Web Sites
Top 10 MHCC Sites during September- October 2008



Web Development for Internal Applications

Health Occupation Boards License Renewals

Staff continued to make progress on license renewal applications for the occupation boards. Table 1 presents the status on development for health occupation boards. The current workload and the limited staff available for develop has forced MHCC to scale back support to the Boards in the last several months.

Table 1– Health Occupation Boards with Web Applications Under Development

Board	Anticipated Start Development/Renewal	Start of Next Renewal Cycle
Physician- Radiation Technicians	Planning	April 2009
Physicians – Physician Assistants	Planning	June 2009
Pharmacy	Planning	Fall 2009

CENTERS FOR HEALTH CARE FINANCING AND LONG-TERM CARE AND COMMUNITY BASED SERVICES

HMO Quality and Performance

2008 Plan Performance Evaluation: HEDIS Audit and CAHPS Survey

HEDIS Audit
Division staff met with HealthcareData Company, LLC (HDC), the CAHPS survey vendor, and representatives from each health plan in preparation for the 2009 audit/survey period. The preparation work for the upcoming year began in earnest with activities that ranged from finalization of auditor assignments to creation of preliminary documents aimed at assisting plans throughout the evaluation process. The annual "kick-off" planning meeting for representatives from each health plan, MHCC contractors for the CAHPS survey and the HEDIS audit, and Division staff has been set for December 11th.

During the October planning session, health plan representatives participated to provide input regarding both mandated and voluntary experiences and recommendations. There was consensus on key matters pertaining to the voluntary involvement by plans, such as following the measurement set established for PPOs by NCQA to complement the accreditation process and to begin building multi-year results to trend performance. By October 16th each health plan notified MHCC about whether it will report performance data, where applicable, for its PPO product. Four carriers submitted results voluntarily in 2008—Aetna, CareFirst, CIGNA, and UnitedHealthcare. All but UnitedHealthcare will continue with this undertaking in 2009. MHCC remains a strong national leader in stimulating health plan quality improvement through public reporting because of the commitment Maryland plans have demonstrated over the years and especially in their willingness to advance the benefits of the process through public-private collaboration.

Consumer Assessment of Healthcare Providers and Systems (CAHPS Survey)
WB&A, the survey vendor, completed all deliverables for the contract year, as defined in the RFP. MHCC withheld five percent of all billed amounts with request for payment of these amounts due with the last invoice. The retained amount was approved for payment based on satisfactory completion of all deliverables, tracking a sample from each mail wave, and increasing the final response rate.

Staff has begun reviewing the CAHPS survey instrument and MHCC-specific questions for use in the 2009 survey. Plans will receive notification this month to confirm use of or to modify any supplemental questions they used previously. Collateral materials, such as reminder postcards, will be edited as needed.

Report Development
Content development continues for the detail rich *Comprehensive Report*. Readers interested in the complete details on methodology, technical considerations, and findings for all measures reported to MHCC find this publication a useful resource. The public can access the final report on the commission's website.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)

At the May public meeting, Commission staff presented the results of the annual surveys submitted by each participating carrier in the small group market. The presentation included updated information on the number of employer groups enrolled, the number of lives covered, average premiums for various plan types, etc. in the CSHBP for the year ending December 31, 2007, as well as the overall cost of the core plan in relation to the income affordability cap, which is set in statute at 10% of the average annual wage in Maryland. For comparative purposes, the report also included enrollment by age and geographic location of the business for both CY 2006 and CY 2007. Since the overall cost of the CSHBP is estimated to be at about 86% of the cap for 2007, the Commission is not required to make any changes to the Standard Plan. However, at the request of the Commission and the General Assembly, staff evaluated the cost of covering dependents up to age 25 and coverage for domestic partners in the small group market. Staff will present recommendations on these two issues later in the meeting. In addition, with increasing information on the cost effectiveness of bariatric surgery, Mercer, the Commission's consulting actuary, is evaluating the cost of adding this covered service to the CSHBP as well. Staff will bring a recommendation to the Commission on coverage for bariatric surgery at the December public meeting.

Health Insurance Partnership

At the February public meeting, the Commission adopted both emergency regulations (for an immediate effective date) and proposed permanent regulations that specify the components of wellness benefits offered under small employer health benefit plans. These regulations are required under SB 6, the *"Working Families and Small Business Health Coverage Act,"* enacted during the Special Session of November 2007. The emergency regulations were approved on April 1, 2008 and expired on August 18, 2008. The proposed permanent regulations were approved at the June public meeting with a final effective date of July 17, 2008. The MIA has approved the wellness riders for the various products that the four participating carriers are offering under the Partnership.

At the August 5th Commission meeting, conducted via conference call, the Commission adopted final regulations to implement (effective August 25th) the new premium subsidy program, the "Health Insurance Partnership" which also was required under SB 6. The Partnership is now available to certain small employers with 2 to 9 full time employees as long as they meet the requirements outlined in the law and meet certain salary, wage and other eligibility requirements established by the Commission through regulation.

Commission staff created and continually maintains the Partnership website (http://mhcc.maryland.gov/partnership) to inform all interested parties, including, carriers, producers, employers, employees, various business associations, etc. about the Partnership. Coverage under the Partnership began on October 1, 2008.

Mandated Health Insurance Services

As required under Insurance Article § 15-1501, Annotated Code of Maryland, the Commission is required to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. This year's report will include an evaluation on the following five (5) proposed mandates:

1. Coverage for prosthetic devices
2. Extending the current mandate on coverage for in vitro fertilization

3. Coverage for the shingles (herpes zoster) vaccine
4. Coverage for autism spectrum disorder
5. Coverage for a 48-hour inpatient stay following mastectomy

Mercer will prepare this report and present it to the Commission at the December public meeting for approval. The report is due to the Governor and the General Assembly by December 31, 2008.

Long Term Care Policy and Planning

Home Health Study
During the 2008 legislative session, HB 558 was introduced, but did not pass. Following a hearing on the bill, the Chairman of the Health and Government Operations Committee asked the Commission and the Office of Health Care Quality to recommend, in the absence of certificate of need (CON) for home health agencies, how best to assure regulatory oversight and quality, how possible adverse effects could be mitigated, and what the fiscal implications of the change would be. The second meeting of the Home Health Advisory Group was held on October 30, 2008.

A review of a survey of state licensing agencies was presented. There was a wide range of responses from no licensure, to licensure of programs, as well as individuals providing care. There was also a presentation of results from a survey of the top performing states on home health measures. Using the Agency for Healthcare Research and Quality (AHRQ's) snapshots, nine states were selected that had a meter score of 75 or higher, since Maryland's score was 75. The data showed that there is not a direct relationship between a state's high performance on home health care with that of a state having or not having CON program. The only consistent observation was that for those states with a CON program for home health, the number of Medicare certified home health agencies per 100,000 beneficiaries was lower than states without a CON program. Results indicated a wide range of oversight from no licensure or CON, to CON need projections and strong training and oversight by licensing staff. There were also presentations by Advisory Group members and the Chair on possible options for regulatory oversight. It was decided that the group should hold a third meeting, which will take place on November 17, 2008.

HB 1187
HB 1187, passed during the 2008 legislative session, relates to both ownership information as well as the financial condition of nursing homes. This bill requires the Secretary of DHMH to convene a Stakeholders Workgroup to make recommendations to the Secretary regarding regulations on: ownership and other information to be required from nursing homes on licensure and relicensure; information on changes in financial condition to be reported to the Department; and other items related to nursing home licensure. A meeting of the Work Group was held on October 21, 2008. OHCQ has drafted and circulated regulations to address these issues.

Hospice Data
The fiscal year 2007 Maryland Hospice Survey was released for online survey completion effective March 5, 2008. Staff has been monitoring survey completion and data cleaning by means of weekly conference calls with OCS, the contractor for the survey. OCS has been following up with Maryland providers to correct any discrepancies found in the data. Work is now underway to finalize the 2007 data and as well as to conduct trend analysis on the past four years of data. In addition, staff is beginning planning work for the FY 2008 Maryland Hospice Survey.

Home Health Data
The 2008 Home Health Agency Survey is due December 8, 2008 for phase I agencies; this includes 27 agencies. Phase I includes those home health agencies with fiscal years ending in March, May and June.

Staff sent out a 30-day reminder notice by email to all of the phase I agencies on November 10, 2008. Staff continues to provide help desk support as required.

Long Term Care Survey
The Commission is in receipt of all submitted surveys, 683 total. Staff is in transition in updating the SAS Programs used in the post collection phase of the survey to clean the data. When this is finalized, staff will review the data for any inconsistencies and write correction edits as appropriate. Once the data is verified, staff will begin the process of preparing public use reports, nursing home guide data, and the assisted living guide data.

Long Term Care Quality Initiative

Nursing Home Family Survey
Nursing Home Family Survey returns continue to be processed. Analysis of results is expected to begin December 1st.

Maryland has enjoyed an atypically high response rate (58%) compared to other states although the national trend is a yearly decline in the national average with some survey's experiencing a 20-25% response.

Long Term Care Web Site Enhancement
Development of the enhanced LTC web site continues. Specifications will be finalized in the next two weeks for presentation and buy-off by Dr. Cowdry.

CENTER FOR HOSPITAL SERVICES

Hospital Services Policy and Planning

Certificate of Need (CON)

CONs Issued

St. Mary's Hospital (St. Mary's County) – Docket No. 08-18-2248
Expansion and renovation project, including addition of 26 medical/surgical beds, 6 obstetric beds, 2 psychiatric beds, 2 operating rooms, 23 emergency department treatment spaces, shell space, relocation of support services, and construction of a hospital annex
Approved with conditions
Estimated cost: $80,841,804

Levindale Hebrew Geriatric Center and Hospital (Baltimore City) – Docket No. 08-24-2247
Construction of a new 3-story patient tower addition, including addition of 38 comprehensive care facility ("CCF") beds acquired from other facilities, addition of 46 rooms allowing conversion of 46 semi-private rooms to private rooms, and renovations to create a new entrance and "town center" commons area
Approved with conditions
Estimated cost: $32,149,178

Modified CONs Issued

Lorien LifeCenter-Ellicott City (Howard County) – Docket No. 05-13-2159
Construct 63-bed CCF
$872,240 increase in project cost
Approved with conditions
Total estimated cost: $6,642.240

CON Letters of Intent

Westphalia Medical Facility (Prince George's County)
Establish an outpatient surgery center with 6 operating rooms
October 3, 2008

CON Applications Filed

Augsburg Lutheran Home and Village (Baltimore County) – Matter No. 08-03-2284
Construct 3-story addition to the current CCF and renovate existing facilities
Estimated cost: $16,792,460.
October 3, 2008

Holly Hill Nursing & Rehabilitation Center (Baltimore County) – Matter No. 08-03-2285
Construct addition for 20 CCF beds and relocation of 28 existing CCF beds with related renovations
Estimated cost: $3,657,475.
October 3, 2008

Holy Cross Hospital (Montgomery County) – Matter No. 08-15-2286
Construct new 93-bed general acute care hospital in Germantown
Estimated cost: $306,324,704.
October 3, 2008

Holy Cross Hospital (Montgomery County) – Matter No. 08-15-2287
Construct 7-level addition at existing Silver Spring hospital replacing central utility plant, loading dock, materials management, morgue, and nursing units. The project will also expand the number of patient rooms, allowing conversion of semi-private to private rooms and provide additional surgical services facilities. Shell-space is included.
Estimated cost: $228,764,000.
October 3, 2008

Pre-Application Conference

Westphalia Medical Facility (Prince George's County)
October 15, 2008

Application Review Conferences

Holly Hill Nursing & Rehabilitation Center (Baltimore County) – Matter No. 08-03-2285
October 17, 2008

Holy Cross Hospital (Montgomery County) – Matter No. 08-15-2286
October 17, 2008

Holy Cross Hospital (Montgomery County) – Matter No. 08-15-2287
October 17, 2008

Determination of Coverage

Acquisitions

Home Health Corporation of America
Acquisition of Home Health Corporation of America, a home health agency serving Somerset, Wicomico, Worcester and Dorchester Counties, by Amedisys, Inc.

Capital Threshold

NMS Healthcare of Hagerstown (Washington County)
Construction of an addition to the existing facility and related renovations
Estimated cost: $2,382,182

Delicensure of Bed Capacity or a Health Care Facility

Fayette Health & Rehabilitation Center (Baltimore City)
Temporary delicensure of 24 CCF beds

Chapel Hill Nursing Center (Baltimore County)
Temporary delicensure of 2 CCF beds

FutureCare-Northpoint (Baltimore County)
Temporary delicensure of 30 CCF beds

Relicensure of Bed Capacity or a Health Care Facility

Briton Woods Nursing & Rehabilitation Center (Baltimore City)
Relicensure of 7 CCF beds

Layhill Center (Montgomery County)
Relicensure of 3 CCF beds

Woodside Center (Montgomery County)
Relicensure of 6 CCF beds

The Pines (Talbot County)
Relicensure of 5 CCF beds

Catonsville Commons (Baltimore County)
Relicensure of 2 CCF beds

Knollwood Center (Anne Arundel County)
Relicensure of 17 CCF beds

Relinquishment of Bed Capacity

Layhill Center (Montgomery County)
Relinquishment of 4 temporarily delicensed CCF beds

William Hill Manor (Talbot County)
Relinquishment of 26 temporarily delicensed CCF beds

The Pines (Talbot County)
Relinquishment of 7 temporarily delicensed CCF beds

Catonsville Commons (Baltimore County)
Relinquishment of 2 temporarily delicensed CCF beds

Loch Raven Center (Baltimore County)
Relinquishment of 4 temporarily delicensed CCF beds

Renaissance Gardens at Charlestown (Baltimore County)
Relinquishment of 9 CCF beds

Ambulatory Surgery Centers

Surgery Center of Potomac (Montgomery County)
Addition of gastroenterology and general surgery as surgical specialties

Waiver Beds

Berkeley and Eleanor Mann Residential Treatment Center at Sheppard Pratt (Baltimore County)
Ten-bed increase in non-MART RTC beds from 24 to 34 beds

Policy and Planning

A 30-day review and comment period began on October 24, 2008 for proposed permanent regulations, State Health Plan for Facilities and Services: Acute Care Hospital Services, COMAR 10.24.10.

The Annual Report on Selected Maryland Acute Care Hospital Services, FY 2009 (previous editions of this report were titled as "Annual Report on Acute Care Hospital Services and Licensed Bed Capacity") was published on the MHCC web site on October 31. 2009. This report provides the inventory of licensed acute care hospital beds, by service, at the state's 47 acute care general hospitals for FY 2009 and also provides information on recent trends in hospital bed capacity, and service capacity for hospital emergency departments, surgical facilities, and obstetric and perinatal facilities.

Hospital Quality Initiatives

Procurement Activities related to the Expansion of the Hospital Performance Evaluation System
In addition to the activities associated with the immediate update of the Guide, the staff continues to work on a long term strategy which entails the establishment a Quality Measures Data Center (QMDC). The QMDC will provide direct and timely access to detailed patient-level quality and performance measures data. This approach will not only accelerate the timely receipt of data directly from hospitals, but it will

enable the Commission to validate the accuracy and completeness of the data as well. Historically, the data (in summary form) have been obtained from the CMS Quality Improvement Organization (QIO) Warehouse. The staff convened an evaluation committee to assist with the selection of a qualified vendor for this project. The proposal review process is well underway and on schedule for a contract start date of January 1, 2009.

Healthcare Associated Infections (HAI) Data

The staff has continued efforts towards implementation of the recommendations of the Technical Advisory Committee on Healthcare-Associated Infections (TAC-HAI). These recommendations include public reporting of compliance with active surveillance testing for MRSA in all ICUs and collection of Health Care Worker Influenza Vaccination data from hospitals. A sub-committee was established to review the use of the newly released NHSN surveillance module for Multi-Drug Resistant Organisms (MDRO) to include active surveillance testing for MRSA as well as alternative data collection approaches. The sub-committee met on October 9th and recommended implementation of a survey instrument to obtain the MRSA data. A separate group was established to review the Health Care Worker Influenza Vaccination data requirements. The group also recommended use of an alternative data collection tool for the initial phase of the data reporting project. The staff will develop the survey instruments for the full HAI committee review and approval in November.

Since July 1, 2008, Maryland hospitals have been required to use the NHSN system to report data to the Commission on Central Line-Associated Blood Stream Infections in any intensive care unit. The hospitals are required by NHSN to report data in the system within 30 days following the end of the month. The staff has worked with the hospitals to facilitate compliance with these new data reporting requirements. All hospitals are participating in the system and are now recording data on CLABSIs in ICUs. The staff reviews the hospital data for compliance on an ongoing basis.

Other Activities

In support of MHCC's hospital quality initiatives, the staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement. The staff collaborates with the HSCRC staff on data issues to support the Quality Based Reimbursement project and broader rate setting issues.

Specialized Services Policy and Planning

Percutaneous Coronary Intervention (npPCI) provides for a limited number of qualified hospitals without on-site cardiac surgical services to participate in the Atlantic Cardiovascular Patient Outcomes Research Team elective angioplasty (C-PORT E) study. On September 18, 2008, the Commission adopted the Executive Director's Recommended Decision, as modified at the public meeting, to grant all six research waivers available under COMAR 10.24.05 by the following process:

- Grant npPCI research waivers to four applicants: Anne Arundel Medical Center (Docket No. 08-02-0032 NPRW), Shady Grove Adventist Hospital (Docket No. 08-15-0027 NPRW), Southern Maryland Hospital Center (Docket No. 08-16-0031 NPRW), and St. Agnes Hospital (Docket No. 08-24-0028 NPRW).
- Hold two waivers in abeyance pending the completion of the review of applications from the Western Maryland Regional Service Area.
- At this time, take no action on the applications filed by Baltimore Washington Medical Center (Docket No. 08-02-0029 NPRW), Holy Cross Hospital (Docket No. 08-15-0033 NPRW), and Johns Hopkins Bayview Medical Center (Docket No. 08-24-0030 NPRW). If the remaining two waivers available under the regulations are not awarded in the review of applications from Western Maryland, Commission staff will look again at the procedure volumes of Baltimore

Washington Medical Center, Holy Cross Hospital, and Johns Hopkins Bayview Medical Center, and make additional recommendations so that all six research waivers are awarded.

The Partial Final Decision is available on the Commission's website at: http://mhcc.maryland.gov/hospital_services/specialservices/cardiovascular/nppci.html.

The Commission's staff held meetings to discuss protocol requirements and waiver conditions with representatives of each of the four hospitals that were granted npPCI research waivers: on October 29th, Anne Arundel Medical Center; and, following in order on October 31st, Shady Grove Adventist Hospital, St. Agnes Hospital, and Southern Maryland Hospital Center. Thomas Aversano, M.D., the Principal Investigator of the C-PORT E study, and Cynthia Lemmon, R.N., Atlantic C-PORT Nurse Coordinator, participated in the meetings.

On October 14, 2008, Frederick Memorial Hospital and Washington County Hospital timely filed applications for a research waiver to provide npPCI services without on-site cardiac surgery as part of the C-PORT E study. Both hospitals are located in the Western Maryland Regional Service Area. The Commission's staff has reviewed each application for completeness and requested additional information to ensure that the application is complete. The requested information is due on November 19th.

On April 17, 2008, the Commission issued a one-year waiver to Carroll Hospital Center (Docket No. 08-06-0026 WN) to provide primary percutaneous coronary intervention (pPCI) without cardiac surgery on-site. As a condition of the waiver, the hospital timely filed bimonthly reports regarding its progress in implementing pPCI services. After review of supporting documentation provided by the hospital, the Commission granted Carroll Hospital Center permission to initiate pPCI services on October 13, 2008.

The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17) includes policies concerning the designation of primary angioplasty centers and the triage of appropriate acute myocardial infarction (MI) patients to a primary angioplasty center. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) has circulated drafts of two documents for informal public comments: Cardiac Center Designation Standards – Draft 2 (COMAR 30.08.15 STEMI Center Standards – Draft 9/15/08), and Proposed Development of a STEMI System in Maryland – October 2008. The documents are available at www.miemss.org.

Calvert Memorial Hospital filed a petition requesting that the Commission amend the State Health Plan for Acute Inpatient Rehabilitation Services (COMAR 10.24.09) to eliminate the docketing and approval rules that require rehabilitation hospitals and units in a regional service area to maintain a certain occupancy rate. The petitioner is an acute general hospital in Prince Frederick, located in the Southern Maryland Regional Service Area. The Commission solicited information and comments on the petition, and the following organizations submitted written comments: Adventist HealthCare; MedStar Health; and Rifkin, Livingston, Levitan & Silver, LLC on behalf of HealthSouth Corporation. On October 10, 2008, Calvert Memorial Hospital submitted comments on the informal public comments. Additional information is available at: http://mhcc.maryland.gov/statehealthplan/index.html.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Health Information Technology

Staff finalized data collection activities from 47 hospital Chief Information Officers (CIOs) on *The Hospital Health Information Technology Survey* (survey). The survey was developed to assess the level of health information technology (HIT) implementation and use within primary care units. The survey allows for comparison with national surveys and is unique in that it assesses clinical data sharing activity within a hospital's service area. Staff is in the early stages of analyzing the data and plans to report on aggregate findings early next year. The Center for Hospital Services is considering including the survey as part of its annual *Maryland Hospital Performance Evaluation Guide*. Staff is in the development phase of a similar survey for freestanding ambulatory surgical centers; the Maryland State Ambulatory Association provided comments on the draft.

Staff continues to promote the Centers for Medicare & Medicaid (CMS) EHR Demonstration Project. Small to medium-sized primary care practices that meet certain participation requirements are eligible to apply to participate in the demonstration project. This is a five year demonstration project in which CMS will provide limited funding for up to 200 primary care physician practices with 20 or fewer physicians to implement an EHR. Staff met with practice administrators and hospital physician liaisons throughout the month to provide an overview of the program and answer questions. Solo practices can earn up to $58,000 and practices with 20 or less physicians can earn up to $290,000. MHCC is collaborating with MedChi, The Maryland State Medical Society, and the Medical Society of the District of Columbia on this project. CareFirst and the Delmarva Foundation continue to share information with physicians about the demonstration project. The application submission phase of the demonstration project ends on November 26th.

Staff recommended to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) a modification to the Hospital Information Management Chapter of their survey manual. The proposed change includes requiring hospitals to use health information management systems that meet national accreditation standards. JCAHO has agreed to modify the information management standard that refers to retrieving, disseminating, and transmitting information to require that these systems be consistent with criteria developed by the Certification Commission for Health Information Technology (CCHIT). In November, JCAHO plans to review with staff revised language to include in the Hospital Information Management Chapter of the survey manual. JCAHO sets standards for health care organizations and issues accreditation to organizations that meet these standards.

Staff is in the planning stages of a project to better understand where long term care fits in terms of HIT adoption and use. Long term care facilities provide care to the fastest growing segment of the population and account for a high portion of the health care dollars spent. To better understand HIT readiness in the state's nursing homes, staff intends to explore issues that impact this stakeholder group specifically related to privacy and security and technology to answer key questions regarding HIT planning and adoption, their readiness to invest in HIT, stakeholder involvement and needed support for HIT adoption in long term care.

Staff provided input to CCHIT's Network Certification Workgroup (workgroup) on their security certification criteria. CCHIT has begun accepting applications from health information exchanges (HIEs) for certification on their basic application and security testing. The Office of the National Coordinator for Health Information Technology (ONC) has awarded CCHIT a grant to fund 50 percent of the certification cost for HIEs that seek accreditation over the next year. CCHIT anticipates that 27 HIEs will seek

certification over the next 12 months. The workgroup plans to expand on the testing requirements during the first quarter of 2009. Staff also continued to provide input to the Electronic Health Network Accreditation Commission (EHNAC) in the criteria development for their HIE privacy and security policy accreditation program.

Health Information Exchange

The Chesapeake Regional Information System for our Patients and the Montgomery County Health Information Exchange continued their planning efforts to build a statewide clinical data sharing utility within the state. Each planning group consists of multiple workgroups focused on addressing issues related to governance, privacy and security, role-based access, user authentication and trust hierarchies, architecture of the exchange, hardware and software solutions, costs of implementation, alternative sustainable business models, and strategies to assure appropriate consumer engagement, access, and control over information exchange. Staff plans to merge the best ideas submitted from the two groups into a single Request for Application to build a statewide exchange that can share information across multiple provider settings. Planning groups remain on schedule to submit a final report by February 20, 2009.

Staff completed the draft outline for the *Service Area Health Information Exchange (SAHIE) Resource Guide* (Guide). The Guide's outline consists of nine sections that address items related to a patient's right to access information, a range of business practice, technical standards, and key financial, organizational, and clinical challenges. At the October SAHIE Workgroup meeting, participants reviewed the outline and developed content for the first three sections. The SAHIE Workgroup consists primarily of hospital CIOs and is facilitated by Dynamed Solutions, LLC. This is a consensus development initiative to identify standards, policies, and business practices related to privacy and security of electronic health information. A virtual meeting of the workgroup is scheduled for late November. Staff anticipates completing the Guide around the beginning of the year.

Staff continues to participate on the Health Information Security & Privacy Collaboration's (HISPC) Adoption of Standards Collaborative Workgroup (workgroup). ONC has subcontracted with the participants of the workgroup to develop recommendations for cross HIE treatment of individuals and populations, and the development of an implementation plan that guides participating states in the adoption of a *National Health Bridge (NHB): Basic Policy Requirements for Authentication and Audit*. At the last meeting, the workgroup evaluated the electronic exchange of laboratory data and medication summaries. The workgroup also considered various approaches to crafting implementation plans for an NHB. Maryland is one of ten states participating on this workgroup. A final report is due to ONC at the end of April.

Staff is evaluating various management services organization's (MSOs) application service provider (ASP) business models that provide physicians with access to electronic health records (EHRs). MSOs offer the potential to overcome some of the traditional barriers that exist to EHR adoption. MSOs eliminate the need for an onsite client server as the technology is stored at offsite locations and participation is on a subscription basis. Staff has identified approximately six different business models ranging from hospital affiliation to independent organizations. Staff anticipates releasing a report during the first quarter of 2009; Erickson Health Information Exchange, LLC, is providing support to this project.

Staff has initiated a review of the 13 recommendations identified in the *Task Force to Study Electronic Health Records* (Task Force) report that was released at the end of 2007. The Task Force was convened as a result of the 2005 legislative session and consisted of 26 volunteer members and included representation from a diverse group of individuals with a broad range of interests in health care and HIT. The directive of the Task Force was to study EHRs, e-prescribing, and computerized physician order

entry. Staff plans to invite a small group of participants from the Task Force to take part in a focus group discussion to consider potential changes to the recommendation contained in the 2007 final report. Staff plans to release a supplemental brief to the report during the first quarter of 2009.

Electronic Health Networks & Electronic Data Interchange
Analysis of the 2007 health care transaction data submitted by the payers in compliance with COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks* was completed in October. A preliminary review of the data indicates that the use of administrative health care transactions increased by nearly three percent from the prior year. Staff plans to develop a Chart Book that reports on the findings in November. This information is used by payers to develop programs aimed at increasing provider use of technology. Staff also met with the Maryland State Dental Association to discuss opportunities for the association to work with its members to increase the use of electronic health care transactions.

Staff did not receive any comments by the October 14th deadline to the proposed changes to COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Claims Clearinghouses*. Modifications to the regulations were approved in September by the Commission and published in the September 12th issue of the Maryland Register. Changes to the regulation will enable the Commission to consider electronic health networks (EHN) certification from other nationally recognized accrediting entities. Last month staff completed its review for candidacy status of three EHNs: Herae, LLC; InstaMed Communications, LLC; and ZirMed, Inc. Presently, 38 EHNs have been certified by MHCC to do business in the state. Staff also participated in a virtual meeting of EHNAC's Criteria and Marketing Committee.

National Networking
Staff participated in several breakout meetings of the Health Information Management System Society (HIMSS). The Personal Health Record (PHR) Clinical Outreach Taskforce continued to develop a FAQs document on PHRs for physicians. The HIE Technology Portfolio Taskforce continued in their efforts to develop a guide that will include principles and resources to support HIE organizations and provide recommendations on how to bolster privacy and security of electronic clinical information. The Healthcare Transformation through Healthcare Information Technology Workgroup discussed the role of HIT in health care reform.

The eHealth Initiative convened a Webinar on privacy and confidentiality issues critical to consumers. A panel discussed privacy and security concerns related to protected health information, the development of a common framework that helps promote a trustworthy environment for information sharing, and the role of the federal and state government in addressing patient privacy and security issues.